

Policy and Procedure	Date Issued 05/15/05	Section Wiser Choice	Policy Number WC-005	Page 1
Milwaukee County Behavioral Health Division	Date Revised 9/20/2011	Subject: Single Coordinated Care Plan		
SAIL				

1. POLICY:

It is the expectation of BHD that a Single Coordinated Care Plan (SCCP) that identifies client strengths, resources, and needs, will be developed for each client who is receiving Recovery Support Coordination or Case Management services. A Recovery Support Team (RST) will develop the SCCP. Decisions regarding eligibility for and continued access to all clinical and ancillary recovery support services will be guided by the needs and priorities indicated in the SCCP. The SCCP will be regularly reviewed and updated to reflect the client's changing circumstances.

2. PROCEDURE:

The Recovery Support Team

- I. Clients that present with the highest degree of risk and need for coordination and/or are eligible for services under special grants or projects will be assisted by the Central Intake Unit (CIU) in choosing a Recovery Support Coordination agency (RSC).

If the CIU has identified any emergency needs, the RSC/CM will:

- Respond and contact the CIU and the consumer within 30 minutes.
- The RSC/CM will review intake screen results, confirm any emergency needs with the client, assist the client in identifying Recovery Support Service (RSS) providers to meet those emergency needs (using RSS Tool), refer the client to those providers, and complete a preliminary Single Coordinated Care Plan (SCCP) which will include a Safety/Crisis Plan that utilizes the client's strengths and natural supports.
- The RSC/CM will complete Service Authorization Requests (SARs) for any services needed. The RSC will send the SARs and a copy of the Preliminary SCCP to BHD.
- Recovery Support Agencies will maintain a discretionary fund for paying for those services that must be purchased sooner than a check can be issued (3 business days). The Agency will pay for those needed services and submit a SAR to BHD for reimbursement.
- The RSC/CM will identify the Recovery Support Team (RST) and meet with the client and RST to identify non-emergency needs and develop a final SCCP. All SCCPs will include a written Safety/Crisis Plan that utilizes the client's strengths and natural supports.

If the CIU has not identified any emergency needs, CIU staff will fax the consent forms to the Recovery Support Coordination agency. The Recovery Support Coordination team supervisor will review the comprehensive screen information available in BHD MIS and assign a RSC/CM within 1 business day.

The RSC/CM will:

- Contact the client within 24 hours to begin identifying the RST and developing the SCCP
- Contact the treatment provider and inform them that he/she is the assigned RSC/CM and provide contact information.

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- II. During the initial meeting with the client, the RSC will begin assembling a Recovery Support Team (RST). The RSC will ask the client whether there are individuals in the client's family or community who may provide natural recovery support for the client and should be included on the RST.
- III. Each Recovery Support Team will include:
 - a. Client
 - b. Recovery support coordinator
 - c. Primary clinical provider,
 - d. Family and/or community members identified by the client
 - e. Representatives of each system the client is involved in (e.g. criminal justice, child welfare, W-2, etc.)
 - f. All other ancillary recovery support service providers.
 - g. New members may be added to the RST as the client accesses additional services or as additional natural supports are identified.

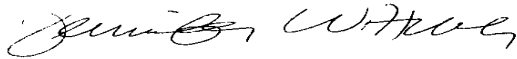
The Single Coordinated Care Plan

- I. The RST meets early in the client's enrollment and develops the Single Coordinated Care Plan (SCCP). At the first RST meeting, the team will use the results of the client's Comprehensive Screen to prepare the SCCP.
- II. Each Single Coordinated Care Plan will include:
 - a. A list of RST members and their contact information.
 - b. A list of RST members in attendance at meeting, as well as those invited who did not attend.
 - c. The date of the initial SCCP team meeting and subsequent SCCP revisions.
 - d. The client's self-described vision of how he/she wants life to be.
 - e. The strengths of the client and other team members that can assist in recovery.
 - f. Specific needs of the client, children and/or other family members, assessed in terms of priority. (Remember that needs are different from services. Needs are related concerns that can be resolved, services are resources used to resolve the concerns.)
 - g. Strategies that describe how the prioritized needs are to be met.
 - h. Updates that describe successes and barriers.
 - i. A date and location for a follow-up meeting.
 - j. The signatures of all participating RST members.
- III. First, the client's vision will be established. Next, the client and RST members' strengths will be identified. Then the client's needs will be addressed and prioritized. Finally, strategies will be developed based on the supports and services available to assist the client in meeting their needs.
- IV. If a need for one or more ancillary recovery support services (RSS) is identified, the RSC will assist the client in choosing a suitable provider for each service, then complete a separate Service Authorization Requests (SARs) for each of those services.

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- V. The RSC will send a copy of the initial SCCP (along with any SARs for ancillary services) to BHD for review.
- VI. The RSC will schedule regular RST meetings and facilitate communication among team members to review progress and update the SCCP as appropriate. Ordinarily, the SCCP will be reviewed and updated at least once a month.
- VII. After each update, the RSC will send a copy of the updated SCCP (along with any SARs for new or a re-authorized services) to BHD for review.
- VIII. At every RST meeting, the RSC will remind team members of their responsibility for maintaining client confidentiality.

APPROVED BY:



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